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ABSTRACT

Longevity has increased tremendously during the 20th century in the United States. Although women live longer today, they can expect increased and longer periods of chronic health problems. Women tend to have more chronic diseases and disabilities than men, partly because of their greater longevity. Breast cancer is the leading cause of death among women. Heart disease is the leading cause of death for women over 65. Osteoporosis affects half of women over age 45 and 9 in 10 women over 75. Hospital use rates for midlife women and men are virtually indentical, but after age 65, men are more likely to be hospitalized than women. Employed women report fewer chronic health problems, days of incapacity, and health-related limitations on their activities than women not in the paid labor force. Most women aged 40 to 65 have employer-provided group health insurance, either through their own or their husband's employment. Women who have group health insurance through their spouse's employment can lose coverage when marital or work status changes. Medicaid does not fill in the gaps for most midlife women. Nearly all women age 65 and over (94 percent) are covered by Medicare, which pays for about half the health expenditures of the elderly. Medicare does not pay for long-term chronic care. Research on sexism in health care delivery has resulted in evidence that health care providers treat women differently from men. Many health research projects are conducted on men only. (A list of 47 sources is included.) (CML)

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OLDER WOMEN'S LEAGUE

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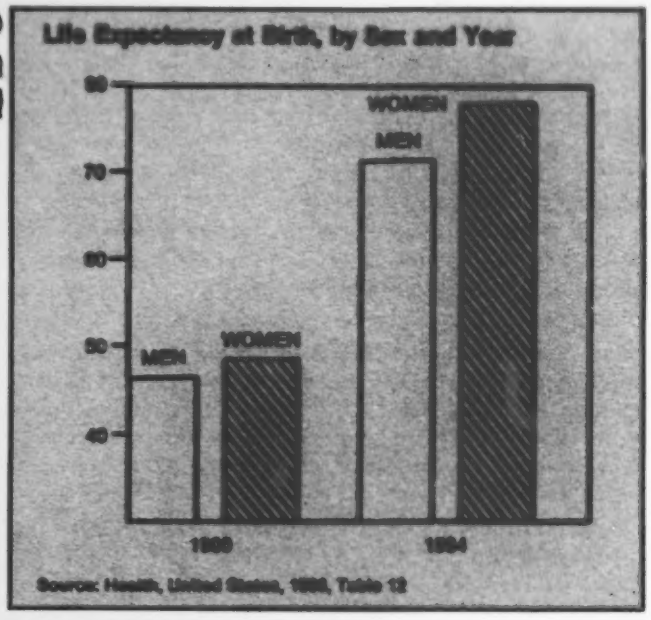
The Picture of Health

For Midlife and Older Women in America

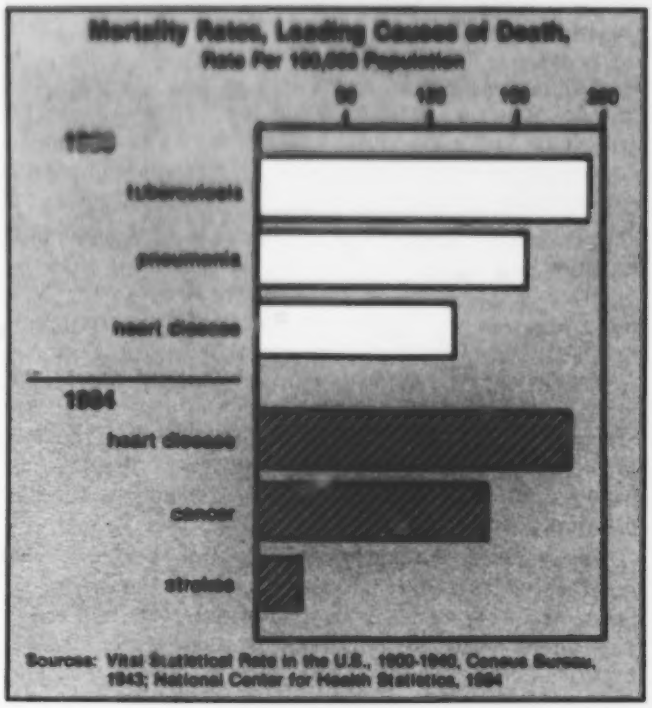
Introduction

Longevity has increased tremendously during the 20th century in the United States due to remarkable advances in modern medicine and public health. In 1900, the life expectancy of a newborn was 48 years for females; today it is 78. The life expectancy for male newborns increased 25 years during the same period.



Largely because of these advances, health and illness patterns have changed dramatically. At the turn of the century, infectious diseases such as smallpox, diphtheria and tuberculosis were leading causes of death. Today, those diseases have been largely wiped out as a cause of death in the United States. Instead, women over 45 die from heart disease, cancer, strokes, diabetes and emphysema—noninfectious diseases that are much more likely to have chronic and debilitating effects.

While American women live longer today, they do not necessarily have longer periods of good health. In several national surveys, Americans who report their health to be fair or poor are disproportionately low-income, uninsured, Black, out of the labor force, and female.



In fact, women can expect increased and longer periods of chronic health problems. These changes in longevity and mortality have a major impact on how America ages—and serious public policy implications.

To be responsive to the needs of the public, health care delivery and payment systems must keep pace with these changes. To a considerable extent, they have not.

Medicare was set up in 1965 to assure that older Americans had access to basic medical care. But just a quarter of a century later, Medicare already has huge gaps in coverage for older women because it does not adequately address the needs associated with chronic health problems.

Midlife women, too, often fall through the cracks between private and public insurance coverage. At a time in their lives when prevention is paramount, women in their forties and fifties often must empty their pockets to pay for routine preventive procedures.

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A Message From Lou Glasse, President of the Older Women's League

Health care is a pressing and often overwhelming concern for older women. Women today live longer than ever before, and Americans can justifiably be proud of the strides made in increasing life expectancy. But the quality of the lives we prolong must also be considered. Women are not experiencing increased periods of good health. In fact, they can expect increased and longer periods of chronic health problems.

In short, our health care system is not adequately addressing the needs of midlife and older women. Neither medical research, health care delivery systems nor payment systems have kept pace with women's changing needs. The goal of this report is to examine what is really happening to women, so that priorities can be reordered and goals established that will lead to change. With Congress considering several crucial aspects of health care delivery and payment systems, the time is ripe to comprehensively assess health care for midlife and older women.

Women face special health problems, and may encounter gender-based biases in the care they receive. Older Black women are at special risk from hypertension and diabetes. Arthritis and osteoporosis are major causes of chronic disability for millions of older women. Osteoporosis is the leading cause of debilitating and costly bone fractures, yet research on this near-epidemic condition has been late getting started and continuously underfunded. There has been an appalling lack of research on work-related problems for post-menopausal women.

One in eleven women gets breast cancer, and both incidence and mortality rates are rising. Breast cancer is now the leading cause of death for women in their forties. But it is also striking women later in life. Four in five breast cancer cases now occur in women over age 50. Yet most public and private health insurance, including Medicare, will not pay for mammograms to detect breast cancer early.

Similarly, uterine and cervical cancer among women over age 60 is increasing at an alarming rate. Yet Medicare will not cover the Pap tests needed to detect the disease early. Since the median annual income for women over age 65 is less than $6,500, the $100 cost of a gynecological examination with a Pap smear can be prohibitive.

There is disturbing evidence of gender-based distinctions in the way that medical personnel treat older women. Studies show that doctors often bring negative preconceptions to their treatment of these patients. In some cases, patient concerns have impelled social service agencies to send "patient advocates" to accompany older women when they see their doctors. Studies show that, when treating older women, doctors take less time with their patients, give less full explanations, and prescribe drugs more often.

The United States is the only industrialized nation besides South Africa which does not provide a national health plan for its citizens. More than 35 million Americans are uninsured; not surprisingly, millions are women who work part-time or are concentrated in low-paying, no-benefit jobs. The new Group Health Insurance Continuation law has helped, but far too many women still find themselves without health insurance during a vulnerable period in their lives.

Our publicly funded programs — Medicaid for the poor and Medicare for the disabled and those over 65 — have huge gaps in coverage. Medicaid does not cover midlife women who no longer have dependent children and are too young to qualify for Medicare. Most widows in their 50s, for instance, do not qualify for either program despite the fact that costs incurred during a husband's illness may have exhausted the couple's life savings. If the widow becomes ill and has no insurance and no money, her only option is to seek indigent care at a free clinic. No government assistance is available to her.

Even older women covered by Medicare face enormous gaps in coverage. Expenses for eye glasses, hearing aids and prescription drugs are not covered, and home health care is covered only on a very restrictive basis. In fact, the restrictions on home health care have been tightened at the very time that the need for this service has grown because of Medicare's prospective payment system, which encourages premature hospital discharges. More and more elderly patients need care at home, and usually it is their wives, sisters and daughters who quit jobs or take extended leave to become "caregivers." When they do, these women often jeopardize their own financial, physical and emotional well-being.

Medicare does not cover long term care, so families must find a way to cover nursing home costs. Contrary to popular belief and largely because of the unheralded work of caregivers, only about one in twenty elderly Americans are in nursing homes. But three out of four of them are women, and the costs can be prohibitive. Nursing home costs average $22,000 per year, or more than three and one half times the average income of an elderly woman. Women whose husbands must be institutionalized fall quickly into poverty as they try to support themselves while paying the nursing home bills.

Women over age 65 are paying more out-of-pocket health care costs under Medicare than are men. To a considerable extent, this program does not meet the

needs of older women. It is long past time to overhaul Medicare and Medicaid to make them responsive to midlife and older women. A catastrophic health care plan which addresses prime areas in which Medicare falls short — prescription drugs, long term care, home health services, dental and vision care, and doctors' fees which exceed the Medicare allowance — has been desperately needed for years.

THE PICTURE OF HEALTH for Midlife and Older Women is a challenge to America's policymakers. The United States is not investing adequately in the research and the prevention that will allow women to live healthier lives. Our nation's insurance system, both public and private, is woefully inadequate. Many midlife and older women with even minor illnesses find themselves in dire financial straits; the consequences of chronic illness can be devastating.

Our health care system is on the critical list and failing daily. We can do better, and we must. The Older Women's League asks policymakers to accept responsibility to take every possible step to meet these needs. The time to act is already overdue.

Lou Glazer

continued from page 1.

These inadequacies cause significant problems for a sizable segment of our society. There are 23 million American women aged 45 to 64 and another 17 million aged 65 or older. More women are employed than ever before, but they remain concentrated in low-paying jobs. The median income of midlife women is approximately one-third that of midlife men; the average income for a woman over 65 is less than $6,500. Thus, the resources available to older women are woefully inadequate to fill gaps in health care coverage.

The picture of health of our nation's midlife and older women is an evolving picture that is constantly altered by break-throughs in research and technology, changing population demographics, and developments in public and private insurance availability. To be responsible, health care delivery and payment systems must keep pace with these changes. A health care policy transfusion is long overdue.

Women's Health Problems

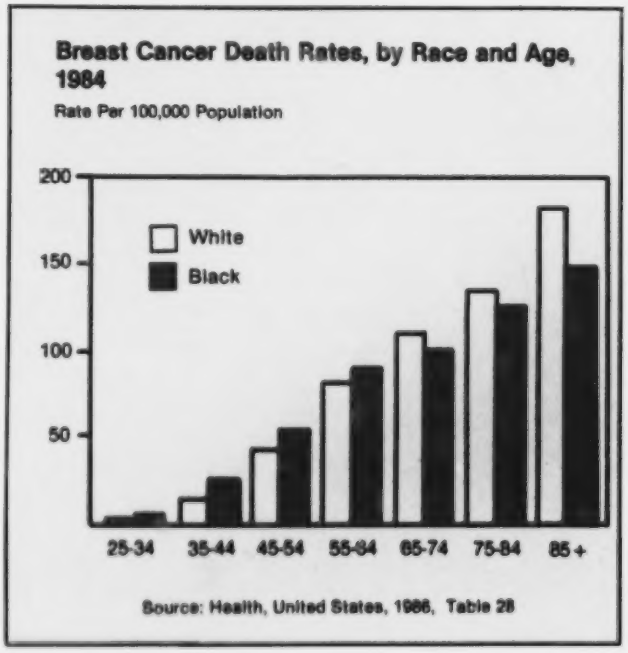
Women tend to have more chronic diseases and disabilities than men, partly because of their greater longevity. Some health problems are faced by both men and women, and in similar proportions; others are unique to women. Still others are age-related, and more likely to appear among women, who make up the majority of the aged population.

Cancer

As a cause of death, cancer is #1 among women 35-54, #2 among women 55-74 and #3 among women over age 75. With the exception of cancers related to smoking, the differences in death rates from cancers common to both sexes is small, although there are variations within types of cancer. But cancers specific to females are devastating.

Breast cancer is the leading cause of death among American women. One in every eleven women in the United States will develop this disease in her lifetime. Currently, the only significant possibility for further improving survival rates is early detection and treatment. Survival from breast cancer has not improved since 1973. Five-year survival rates are considerably higher for white women (75%) than for Black women (63%).

Regular breast self-examination and mammography are the most effective and proven means of early detection. Studies suggest that the combined use of less radical surgery and radiation is as effective as the more radical surgery used in the past. More research is needed to confirm this and to resolve issues of toxicity, side-effects, and psychological implications of the various courses of treatment.



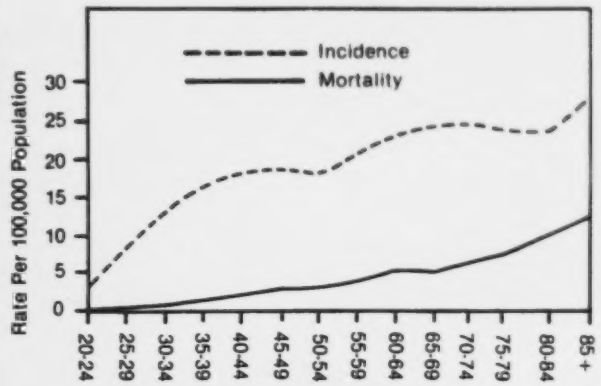
The risk of reproductive tract cancers increases with age. Among the most common are endometrial, cervical, and ovarian cancers. Cancer of the endometrium (uterine lining) is the most common reproductive tract cancer.

This disease occurs primarily in menopausal and post-menopausal women, and is associated with hypertension, obesity, and long-term estrogen replacement therapy.

Each year, 10,000 American women die of uterine cervical cancer; nearly half of them are over 60. The cure rate for cancers of the cervix is now 85%. This is largely attributed to widespread availability of the Papanicoleau (Pap) smear, a quick and safe screening method that has led to increased diagnosis of pre-malignant or early cancerous conditions of the cervix.

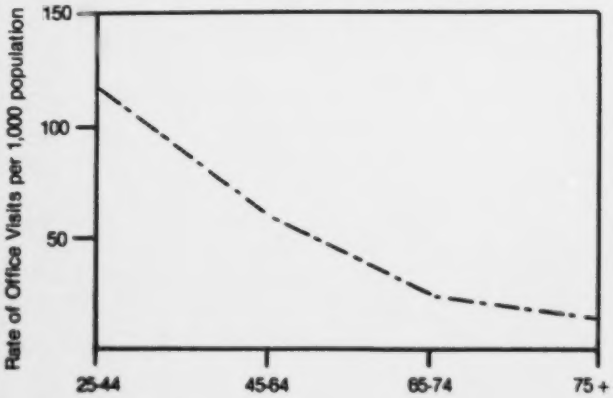
Tragically, women over 60 are least likely to have annual Pap smears, or to have *ever* had this screening. Lack of a prior Pap smear is the most common reason for the non-detection of invasive cervical cancer. Medicare and most private health plans do not pay for such preventive tests and screenings.

Cervical Cancer, by Age, 1978-81



Source: National Cancer Institute Surveillance, Epidemiology, and End Results (SEER) Program

Office Visits for Pap Smear, by Age, 1978



Source: Use of Health Services by Women 65 Years of Age and Over, U.S. (Vital and Health Statistics, Series 13, No. 59) 1981

Most Common Surgery for Midlife and Older Women, 1984

Age 45-64	Age 65 +
hysterectomy	cataract removal
dilation & curettage (D&C)	insertion of lens
cardiac catherization	treatment of fracture
tissue biopsy	hip replacement

Source: L. Verbrugge. From Sneezes to Adieux. American Demography May 1986

While far less common than cervical cancer, ovarian cancer has a significantly higher death rate, due to the lack of mass screening technique for early detection. Once discovered, ovarian cancers require removal of the tumor and aggressive chemotherapy. This treatment now results in a two-year survival rate of 70% (up from 30% less than five years ago). Serum markers now being tested may allow future mass screening and earlier diagnosis through blood tests.

By far the fastest growing cancer among women is lung cancer. Although the incidence of lung cancer among men is far higher, rates for women have been rising since the 1960's, reflecting the increase in female smoking that began in the 1930's. For several years, experts have predicted that lung cancer will surpass breast cancer as the leading cause of death among women, but this has not yet happened. The American Cancer Society again predicts that more women will die from lung cancer than breast cancer in 1987.

Heart Disease

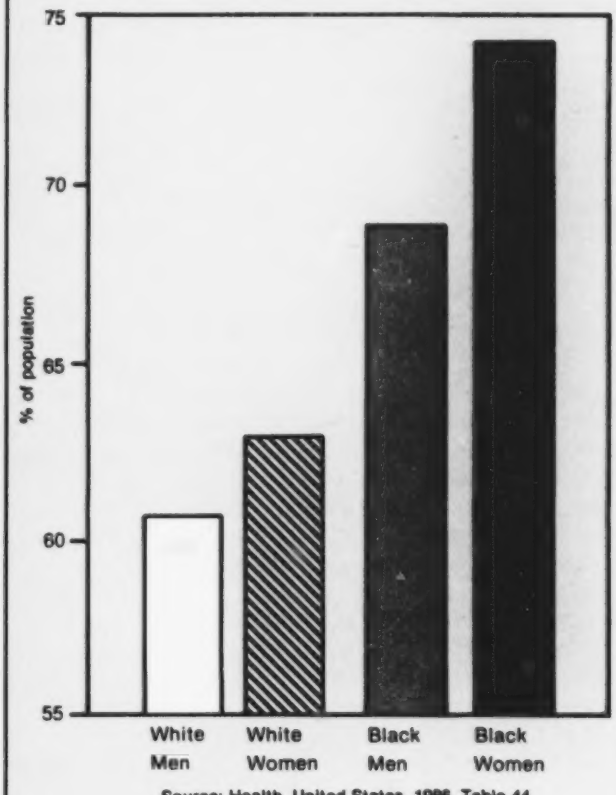
Heart Disease is the leading cause of death for women over 65. Black women are at greater risk than white women, except the very old. Death rates for diseases of the heart have been declining steadily since the 1960's, due partly to progress in prevention, especially smoking cessation, control of high blood pressure and reduction of serum cholesterol. Overall, women have only about half the coronary heart disease of men, but they have no survival advantage once the disease becomes overt. In fact, women who have heart attacks are more likely to die from them than men in nearly every age group.

Hypertension

About two in five persons over age 65 have high blood pressure. Hypertension increases with age, is twice as prevalent among Blacks as whites, and generally affects men more than women. But older Black women have the highest rates of hypertension of any group.

High blood pressure is the most common cause of increased risk of heart disease and vascular disease. Both sexes benefit from reducing blood pressure to prevent future cardiovascular disease. There is no detectable cause of the disorder in more than 90% of those who have it. Women who use oral contraceptives have a greater tendency to have strokes at an early age than women not taking the pill.

Prevalence of Hypertension Among Persons Age 65-74, by Sex and Race, 1976-80



Source: Health, United States, 1986, Table 44

Osteoporosis

Osteoporosis, a condition marked by thinning of the bones after age 35, affects half of women over age 45, and fully nine in ten women over 75. Osteoporosis is implicated in many bone fractures, which are a leading cause of hospitalization among older women.

Sex differences in bone loss are dramatic. Between 40 and 50, men lose less than 1% of bone mass yearly. But women's loss is twice that rate, and following menopause may be four times the rate of men. Men have 30% more bone mass than women, and Blacks 10% more than whites. High risk groups thus include slender white women.

Alzheimer's Disease

Alzheimer's disease accounts for about 75% of dementia among the elderly. It is a crippling organic brain disorder, manifested in intellectual deterioration, loss of recent memory, and behavioral and personality changes. Its victims are somewhat more likely to be female, possibly a function of women's greater longevity. As a degenerative condition, Alzheimer's has a very high "secondary victimization" rate, taking an excessive toll on family caregivers, most of whom are women.

Health and Women in the Workplace

Women have entered the workplace in dramatic numbers in recent decades, with significant implications for health status and health access. About half of all women between 45 and 65 were in the paid labor force in 1986. For midlife women, employment brings current income, the opportunity to earn Social Security and pension credits for retirement and—of key importance to millions—health insurance.

Employment and Health Care Coverage

About 85% of all private health care coverage in the U.S. is group coverage through employment. But millions of full-time workers are uninsured. More than half of them work in the retail trade or service sector; three-fourths of uninsured workers earn less than $10,000 annually. Because women are more likely to be low-wage earners employed in the service sector and in small businesses, or in part-time jobs with no employee benefits, women predominate among the employed uninsured.

For midlife women, coverage is related both to employment and marital status. Married women are more likely to have coverage than widows or divorced women, whether in or out of the labor force.

Private Health Insurance Coverage of Women 35-64, by Employment and Marital Status

	% with private health coverage
Married	
employed	93.0%
not in labor force	86.7%
Widowed	
employed	85.9%
not in labor force	51.4%
Divorced	
employed	76.9%
not in labor force	32.4%

Source: Berk, American Journal of Public Health 74 (Nov. 1984), 1276

Health Care Utilization

Misconceptions about employed women's health status persist, despite data that show little difference between men and women. Studies suggest that the number of sick days women use is not significantly different from men, and that women are more likely to use non-work days to manage health problems. Other studies show that employed women have more days of restricted activity and lose on average just one half-day more per year from work than male counterparts. Such differences are minimal when allowances are made for women's reproductive role, and may also be due to their family caregiving responsibilities rather than their own health problems.

Hospital utilization rates for midlife women and men are virtually identical. After age 65, men are *more* likely to be hospitalized than women, although women on average stay slightly longer. Employer belief that the cost of providing health coverage for midlife women workers will be greater is not based on fact.

Hospital Utilization Rates by Sex and Age, 1984

	45-64		65+	
	Women	Men	Women	Men
Hospital Discharges (per 1000)	181	186	384	425
Average length of stay (days)	7.2	7.1	9.0	8.8
Operations (per 1000)	133	119	205	255

Source: Health, United States, 1986, Tables 56, 59, 62

Employed women report fewer chronic health problems, days of incapacity, and health-related limitations on their activities than women not in the paid labor force. Both groups report about the same number of physician visits. Employed women have lower hospitalization rates, but the differences narrow after age 45. Women in "higher status" jobs, especially those over 40, report better health than women in jobs with "lower status".

Impact of Workplace on Health

Work-related health problems vary with occupation. Among midlife workers, there is not much difference in work days spent in bed (bed disability days) each year: 4.0 days for white collar and blue collar workers, and 5.5 days for service workers.

Nearly three out of four midlife women in the labor force are in clerical, other administrative, service, professional or managerial jobs. Workplace hazards in these occupations include: prolonged standing/sitting/restricted movement; poor lighting; inadequate ventilation; noise; and stress. Many chronic conditions may result: foot/leg/back/neck pain; varicose veins; muscle strain; metacarpal tunnel syndrome; visual problems; fatigue; and other stress-related health problems.

Environmental health effects often take a long time to become evident and are very difficult to trace to a single cause. Unless occupationally-related health conditions are acute, they are not usually attributed to the workplace that induced or contributed to them.

In the past, workplace and health studies have focused on traditionally male occupations. More recently, research efforts have examined occupational hazards unique to women or in predominantly female occupations, often studying the health consequences on pregnancy and childbirth. Few studies have examined the effects of work on health for women over 45.

Health Care Coverage for Women

Women pay for health care through private insurance, public insurance, and out of their own pockets. But age 65 is the continental divide. Before age 65, most women pay for their health care through private insurance; after age 65, most pay through Medicare and private supplements, out-of-pocket, and Medicaid.

How Midlife Women Pay for Health Care

Most women between the ages of 40 and 65 have employer-provided group health insurance, either through their own or their husband's employment. But more than 35 million Americans under age 65 have no health insurance coverage from any source. Nearly five million of them are women over 40, and their dependent children account for many more of the uninsured.

Uninsured Midlife Women by Age, 1984

Age	Number Uninsured	Rate of being Uninsured
45-49	729,000	12.6%
50-54	792,000	13.9%
55-59	826,000	13.8%
60-64	907,000	15.7%

Source: AARP, Health Insurance Status of Midlife Women, 1986, p. 7

Fewer women than men have group health insurance. In 1984, almost a million more women than men had no health insurance; 14% of midlife women were uninsured compared with 11% of midlife men. Between 1980 and 1984, the number of uninsured midlife women increased by about 200,000. The risk of being uninsured increases with age, decreases with family income, and varies with marital and employment status.

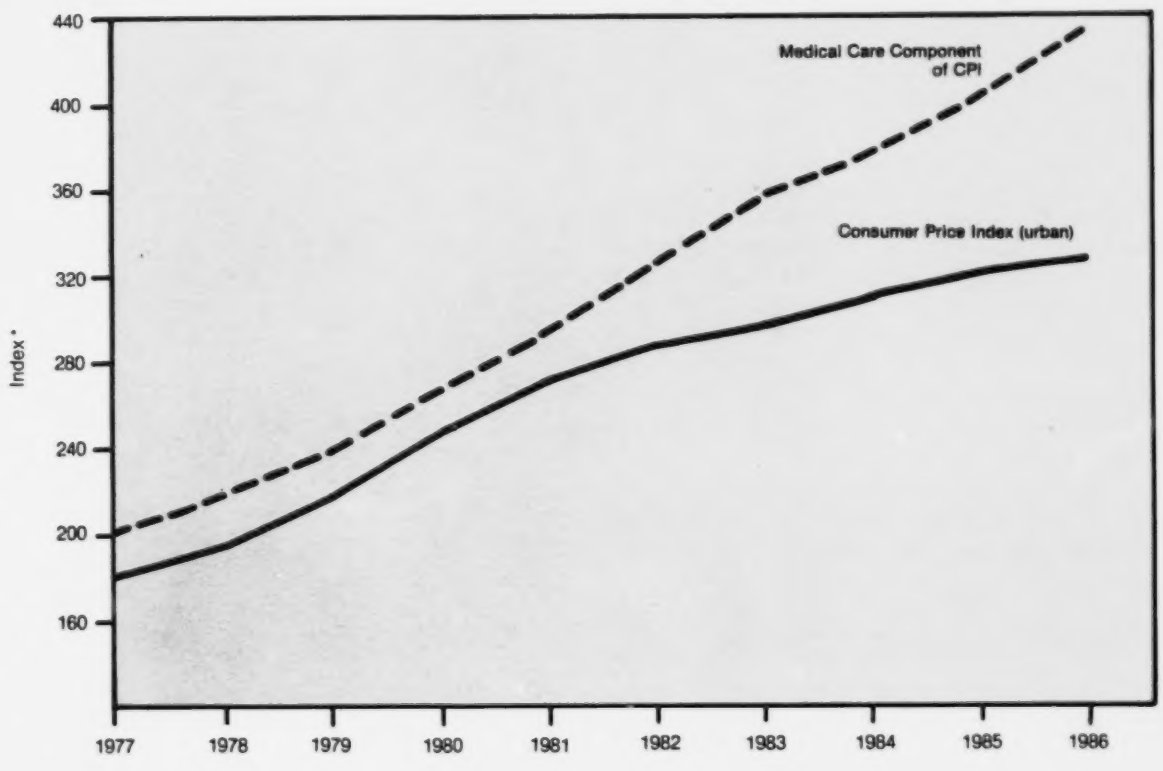
Women who have group health insurance through their spouse's employment can lose coverage when marital or work status changes. A federal law enacted in 1986 provides transitional coverage, but is not retroactive. Midlife women who are widowed, divorced, or separated are almost twice as likely to be uninsured as married women.

Lack of health insurance is also related to income. In 1984, more than one in three midlife women below the poverty level had no health insurance, while only one in twenty with income of at least 3 times the poverty level was uninsured.

High-risk individuals have difficulty getting health insurance. Without group coverage, thousands of midlife women who have been diagnosed with cancer, diabetes, or other "pre-existing" health conditions cannot obtain private individual health insurance at any price.

Lack of health insurance significantly reduces the amount of health care women purchase. It also increases the percentage of income they must pay out-of-pocket for medical expenses. In 1980, uninsured midlife women spent only one-third as much on medical care as women with insurance, although there is no evidence that their medical needs were any less. Eighty percent of their medical expenses came directly out-of-pocket, compared to only 27% of the medical expenses of those with insurance. In addition, health care costs have been rising faster than general inflation for the past ten years.

General Inflation and Medical Costs, 1977-86



*1967 = 100

Source: Bureau of Labor Statistics

Even for those with insurance, many of the preventive services women need are not covered. In 1985, only 13% of all workers were covered by private health insurance that included a routine physical.

Medicaid does not fill in the gaps for most midlife women. Jointly funded by federal and state governments, Medicaid pays for a broad range of health care, including physician, hospital, and nursing home expenses. But Medicaid is required to cover only two groups of low-income persons: those who qualify for Aid to Families with Dependent Children (AFDC) or Supplemental Security Income (SSI). If a woman does not have children under age 18 or is not over 65, blind or disabled, she cannot qualify for Medicaid no matter how low her income is. Typically, to qualify for Medicaid, an applicant must have less than $1,800 in assets and $340 per month in income. Many midlife women without private insurance are too young for Medicare and unable to get Medicaid because they have grown children or are not quite poor enough.

How Older Women Pay for Health Care

Nearly all (94%) women age 65 and over are covered by Medicare, which pays for about half the health expenditures of the elderly. But consumers still bear a large portion of the costs of their health care. Out-of-pocket payments represent the second largest source of payment, after Medicare, and were an estimated $1,575 per person in 1984.

Medicare's emphasis on "acute care" hospitalization and physician services penalizes older women. Because many of their chronic health care needs are not covered, older women must pay a greater percentage of their income on medical expenses. It is estimated that in 1986 Medicare paid for 49% of the total health care expenditures of unmarried men over age 65, 44% of the total health care expenditures of married couples over 65, but only 33% of the total health expenditures of unmarried older women.

Unmarried women age 65 and over spent a greater percentage of their incomes on health care (16.3%), than did either unmarried older men (12.2%) or older married couples (8.9%). This is due both to women's lower median incomes and to their greater likelihood of having health needs that Medicare does not pay for.

Services not covered by Medicare include: preventive health screenings and examinations (for example, Pap smears and mammograms); eyeglasses; hearing care; dental services; all outpatient prescription drugs; and all long-term or chronic nursing home care. Many of these services, particularly prescription drugs and long-term care, are used extensively by older women.

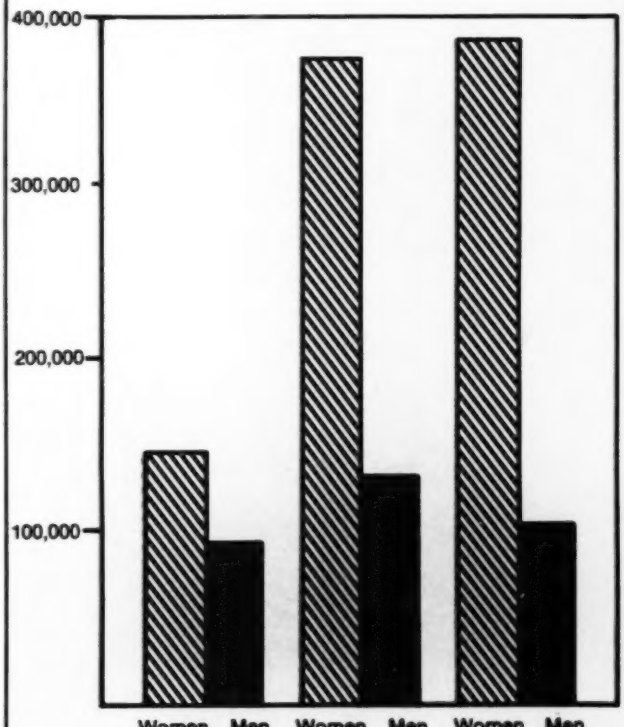
Long Term Care

Women are the primary users of long term care because they have more chronic health problems and live longer than men. "Long term care" includes in-home services, adult day care, and care in resident facilities, convalescent homes, intermediate care and skilled nursing facilities.

The majority of the elderly are not in nursing homes. Contrary to popular belief, only 5% of the elderly are institutionalized at any given time; 20% may require nursing home care sometime during their lifetime. The chance of institutionalization increases with age. Only 2% of persons between 65 and 74 are nursing home residents, compared with 22% of those over age 85.

The need for long term care services varies substantially by gender and age. Women reside in nursing homes at about twice the rate of men. But they also outnumber older men, especially in the oldest age categories where nursing home use is greatest. Among the 1.2 million elderly residents of nursing homes, about 900,000—almost 75%—are women.

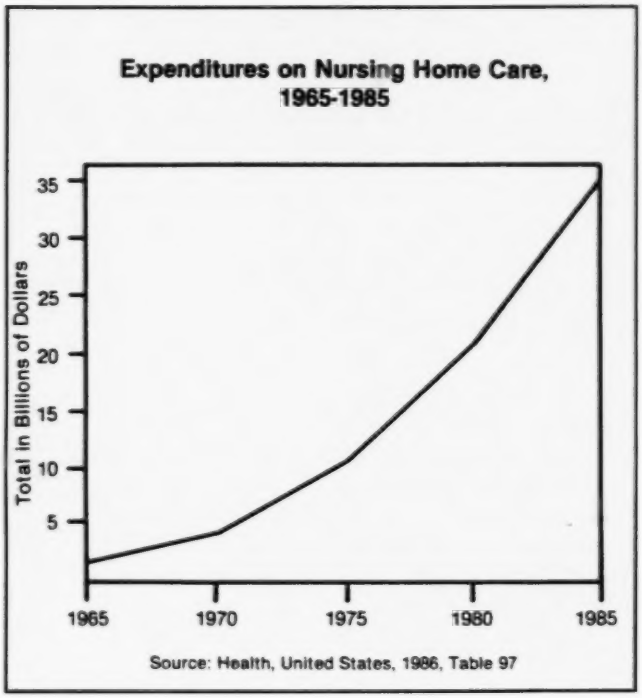
Nursing Home Residents, by Sex and Age, 1980



Source: Census Bureau, PC 80-2-4D, Oct. 1984, Table 17

Paying for Nursing Home Care

In 1985, about $35 billion, or 8% of national health care expenditures, was spent for nursing home care. This is three times the amount spent a decade ago, and sixteen times what was spent in 1965 when Medicare and Medicaid were established. At the same time, current public and private expenditures for home health care and other community-based long term care are only a small fraction of the amount now spent on nursing homes.

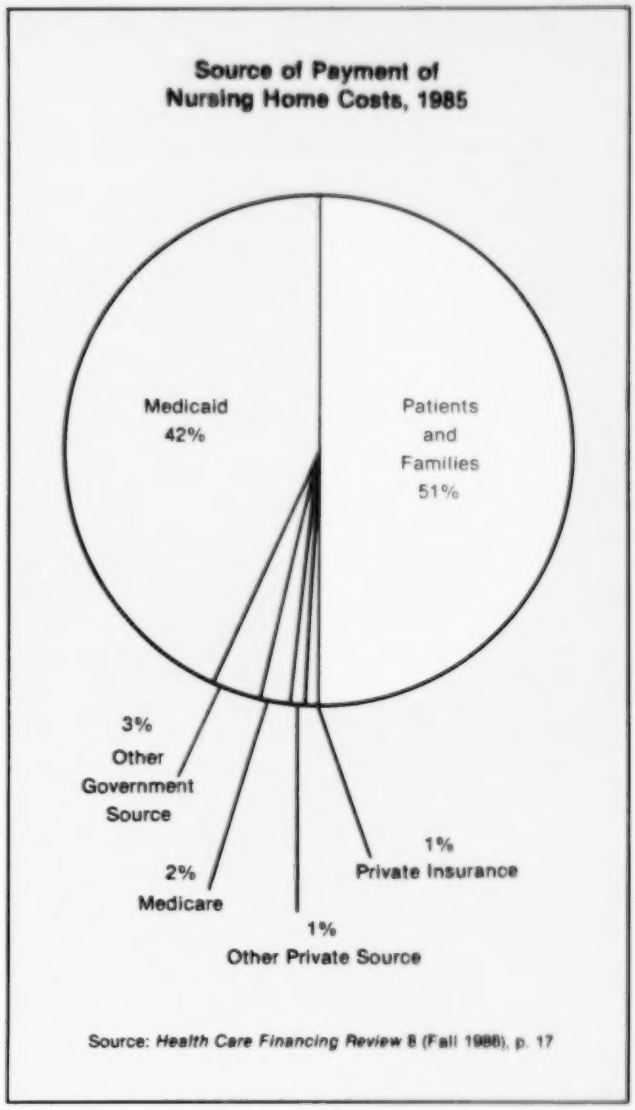


Source: Health, United States, 1986, Table 97

Medicare does NOT pay for long-term chronic care. Unfortunately, millions of elderly persons and their younger family members incorrectly believe that it does. In fact, *only* if *skilled* nursing care is needed *after* discharge from a hospital will Medicare pay for 20 days of nursing home care and assist with the cost of 80 additional days. In 1985, less than 1% of Medicare expenditures was spent on nursing home care.

The average cost of one year in a nursing home is approximately $22,000. This is more than the median income of elderly couples (about $18,000) and several times the median income of older women ($6,313). Most older women cannot pay for their own long term care and are often impoverished if their spouses need such care.

About half of the country's total nursing home bill is paid by residents and their families. But personal savings are quickly expended. One study estimated that two out of three elderly would exhaust their financial resources within the first year of a nursing home stay. Consequently, Medicaid, a program designed to fund health care for the poor, has become the predominant public payor of long term care.



Source: *Health Care Financing Review* 8 (Fall 1986), p. 17

Many women face the financial nightmare of "spousal impoverishment." Once a spouse becomes eligible for Medicaid, much of the couple's monthly income may be considered available to pay the nursing home bill. The non-institutionalized spouse may then keep only a small "spousal maintenance allowance" for living expenses. Women are more likely than men to be pauperized in this way both because they are less likely to have income in their own name and because they tend to outlive their husbands.

Care at Home

Millions of elderly, most of them women, need home-based care. In 1982, about 4.6 million noninstitutionalized persons over age 65 were considered disabled; they needed assistance with personal care (such as bathing, dressing, eating) or with other daily activities (such as meal preparation or shopping). About 65% of these elderly persons are women.

Sources of Home Care for the Disabled Elderly, 1982

	Disabled Elderly	
Source of Care	**Number**	**% of Total**
unpaid care only	3,255,000	74%
paid and unpaid care	907,000	21%
paid care only	242,000	5%

Source: Health Care Financing Review 7 (No. 2, Winter, 1985), p. 52

Coverage of home care is extremely limited under both Medicare and Medicaid. Few private insurance policies cover at-home care, either, although more are doing so. Most home-based care is provided by unpaid caregivers, primarily female relatives. They receive no pay, no benefits, and little relief from this demanding work.

The average age of caregivers of the elderly is 57. But more than one in three is over age 65, indicating that the informal care system is composed in part of the "young-old" caring for the "old-old." About one-third of family caregivers are employed, but many reduce their hours or quit work altogether in order to meet caregiving responsibilities. The average woman today can expect to spend as many years caring for a dependent parent as she does in caring for a dependent child.

By the year 2010, average female life expectancy is projected to increase to 86.1 years, and the number of women over age 85 will more than double. Now and in the future, the cost and availability of long term care and the lack of public and private financing alternatives are a critical concern of women.

Gender Differences in Health Care

Since medicine reflects society, it is hardly surprising that sexism manifests itself in health care. Medical personnel, and doctors in particular, bring preconceptions to their interaction with patients that can work against midlife and older women. Too often women are omitted from research on aging and on diseases that affect both genders. Research on health problems that affect mostly women may be underfunded. Until recently, women in health occupations were predominately nurses. Only now are more women becoming doctors.

Gender Differences in Physician Practice

Research on sexism in health care delivery has resulted in evidence that health care providers treat women differently from men. Several studies conclude that physicians give women a less thorough diagnostic evaluation than men with similar complaints, are more likely to give women prescriptions as part of office visits, and provide less explanation in response to questions from women than from men. Sex bias is one explanation for these differences.

There is evidence of gender differences in physician attitudes. One study of physicians showed that 65% felt women's complaints were influenced by emotional factors, 25% felt women were more likely than men to make excessive demands, and 21% thought women's complaints were more likely than men's to be psychosomatic.

Advocates have long claimed that women are more likely to undergo unnecessary surgery, such as hysterectomies. The most recent study of hysterectomy in the U.S. is inconclusive, however, partly because there is no agreement about the definition of "necessary." The research could confirm the preoperative diagnosis in only half of all hysterectomies; the diagnostic pathological examination showed *no* abnormalities in one in five cases.

Sexism in Research

Sexism in research is common, often by simply omitting women from the study. Important knowledge of aging-over-time is based on longitudinal studies that excluded women. The Baltimore Longitudinal Study of Aging, the leading long-term research study of the nature and experience of aging in the United States, ran for 20 years before finally adding women in 1978.

Many health research projects are conducted on men only. This is based on the justification that women's hormonal cycles make controlled conditions difficult. But findings based on research on men may then be inappropriately applied to women. Studies show that women with high blood pressure have fewer strokes and heart attacks than men with high blood pressure; yet treatment for both is based on the male model.

Research on prescription drugs also usually involves only males. The reason is to prevent possible reproductive hazards to female subjects in the study. But such drugs as anti-arthritics, tested on young men for a year or less, are then prescribed to older women for many years, with little research on appropriate dosage for women and without any research on the long-term effects on older women.

The increase of women at all levels of medical practice and research will likely change some of these practices and research protocols. This year, 1987, marks the first time that more female freshman college students say that they are planning to become physicians than nurses. Twenty years ago, among female college students, prospective nurses outnumbered prospective physicians three to one.

Sources

Sources are listed in alphabetical order by author for each section in which they appear.

Introduction: Census Bureau, *Vital Statistical Rates in the U.S., 1900-1940* (1943); S. Chapman, et. al., "Life Expectancy and Health Status of the Aged," *Social Security Bulletin* 49 (Oct. 1986), 24-48; Robert Wood Johnson Foundation, *Special Report* (No. 1, 1983); L. Harris for Commonwealth Fund Commission, *Problems Facing Elderly Americans Living Alone* (1987); L. Harris for National Council on the Aging, *Aging in the 80's: America in Transition* (1981); Public Health Service, *Health, United States, 1986* (1986); L. Verbrugge, "Longer Life but Worsening Health? Trends in Health and Mortality of Middle-Aged and Older Persons," in *Health and Society* 62 (No. 3, 1984), 475-519.

Women's Health Problems: American Cancer Society, *Cancer Facts & Figures-1987* (1987); Boston Women's Health Book Collective, *The New Our Bodies, Ourselves* (1984); College of American Pathologists, "Uterine Cervical Cancer" public service spot (1986); L. Krakoff, "Hypertension in Women," in *Health Needs of Women as They Age* (1985); J. Mandelblatt et. al., "Gynecological Care of Elderly Women," in *Journal of the American Medical Association* 256 (Jul. 18, 1986), 367-371; National Cancer Institute, "Surveillance, Epidemiology and End Results (SEER) Program"; National Center for Health Statistics, *Use of Health Services by Women 65 Years of Age and Over* (Series 13, No. 59, 1981), and *Patterns of Ambulatory Care in Obstetrics and Gynecology* (Series 13, No. 76, 1984); National Institute on Aging, *Special Report on Aging* (1981); National Institute of Arthritis, Information Office and "Scientific Workshop: Research Directions in Osteoporosis," (1987); Public Health Service, *Health, United States, 1986*, and *Smoking and Health: A National Status Report* (1987); L. Verbrugge, "A Health Profile of Older Women with Comparison to Older Men," in *Research on Aging* 6 (Sept. 1984), 291-322.

Women and Health in the Workplace: M. Berk, "Women and Divorce: Health Insurance Coverage, Utilization, and Health Care Expenditures," in *American Journal of Public Health* 74 (Nov. 1984), 1276-1278; Boston Women's Health Book Collective, *The New Our Bodies, Ourselves,* (1984); Bureau of Labor Statistics, *Employment and Earnings* (Aug. 1986); Census Bureau, *Disability, Functional Limitation and Health Insurance Coverage: 1984-85* (P-70, No. 8, 1986); S. Chapman et. al., "Life Expectancy and Health Status of the Aged," in *Social Security Bulletin* 49 (Oct. 1986), 24-48; D. Chollet, Employee Benefit Research Institute, *Uninsured in the United States: The Nonelderly Population without Health Insurance* (Mar. 1987); C. Muller, "Health and Health Care of Employed Women and Homemakers," in *Women and Health* 11 (Spring 1986); Public Health Service, *Health, United States, 1986;* D. Rice and A. Cugliani, "Health Status of American Women," in *Women and Health* 5 (Spring 1980); Women's Bureau, U.S. Dept. of Labor, *Women and Office Automation: Issues for the Decade Ahead* (1985); K. Yordy, "Health Statistics Make a Difference," in *Proceedings of the 1985 Public Health Conference on Records and Statistics,* National Center for Health Statistics (1985).

Coverage: General Accounting Office, *Health Insurance: Comparison of Coverage for Federal and Private Sector Employees* (Dec. 1986); Health Care Financing Administration, *Health Care Financing Program Statistics: Medicare and Medicaid Data Book, 1984* (June 1986); ICF Incorporated, *Medicaid's Role in Financing the Health Care of Older Women,* prepared for the American Association of Retired Persons (Dec. 1986); F. Leonard, *Health Care Financing and Midlife Women: A Sick System,* Older Women's League (1986); Older Women's League, "Group Health Insurance Continuation: A New Law May Help You. . . ," (Oct. 1986); K. Schwartz and M. Moon, *The Health Insurance Status of Midlife Women: The Problem and Options for Alleviating It,* Urban Institute, prepared for the American Association of Retired Persons (Dec. 1986).

Long Term Care: Census Bureau, *Persons in Institutions and Other Group Quarters* (PC80-2-4D, Oct. 1984); General Accounting Office, *An Aging Society: Meeting the Needs of the Elderly While Responding to Rising Federal Costs* (Sept. 1986); K. Liu et. al., "Home Care Expenses for the Disabled Elderly," in *Health Care Financing Review* 7 (Winter 1985), 51-58; National Center for Health Statistics, *Nursing Home Characteristics* (Advance Data, No. 131, Mar. 27, 1987); Select Committee on Aging, House of Representatives, *Exploding the Myths: Caregiving in America* (Com. Pub. No. 99-611, Jan. 1987); D. Waldo, "National Health Expenditures, 1985," in *Health Care Financing Review* 8 (Fall 1986), 1-21.

Gender Differences: K. J. Armitage et. al., "Responses of Physicians to Medical Complaints in Men and Women," in *Journal of the American Medical Association* 241 (1979), 2186-2187; B. Bernstein and R. Kane, "Physicians' Attitudes Toward Female Patients," in *Medical Care* 19 (June 1981); K. Irwin et. al., "Hysterectomy Among Women of Reproductive Age, United States, Update for 1981-1982," in *Centers for Disease Control Surveillance Summaries: MMWR* 35 (No. 1SS, 1986); N. Lee, et. al., "Confirmation of the Preoperative Diagnosis for Hysterectomy," in *American Journal of Obstetrics and Gynecology* 150 (No. 3, Oct. 1984), 283-287; L. Verbrugge and R. Steiner, "Prescribing Drugs to Men and Women," in *Health Psychology* 4 (1985), 79-98; J. Wallen et. al., "Physician Stereotypes about Female Health and Illness," in *Women and Health* 4 (No. 2, 1979).

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About OWL

This 1987 Mother's Day Report by the Older Women's League is the second in a series begun last year with OWL's *Report on the Status of Midlife and Older Women in America.* That report made clear that the dream of a secure golden age is nothing short of a fairy tale for millions of midlife and older women. *THE PICTURE OF HEALTH for Midlife and Older Women* focuses the spotlight on the health and health care problems women face as they age.

Making these invisible problems visible was the main impetus behind the Older Women's League when it was founded in 1980. OWL is a nonprofit membership organization, the first national organization to focus solely on the concerns of midlife and older women. Its goals are to achieve economic and social equity for older women, to improve their image and status, and to provide mutual support for its members. In just seven years, OWL has become firmly established as a national voice for older women—a segment of the population that has long been unrepresented.

OWL was conceived by two California women, Tish Sommers and Laurie Shields, whose earlier work to eradicate the job inequities midlife women face helped to create the displaced homemakers movement. Although Sommers died in 1985, her legacy continues in the nearly 20,000 OWL members of all ages and both sexes and more than 100 OWL chapters throughout the United States, all working to address the economic and health problems women face as they age.

OWL's national agenda, set by its members, consists of seven issues on which education and advocacy focus: Social Security, pensions, job discrimination, access to health care, family caregivers, budget cuts, and staying in control to the end of life. Education takes many forms: consumer reports and pamphlets, the bi-monthly OWL OBSERVER, testimony before legislatures, media outreach, Gray Paper series, conferences and leadership training. OWL's leaders come mostly from local chapters, whose members work on the national agenda, on state and local concerns, and on bringing women together for mutual support.

OWL's motto is "Don't agonize—organize!" You are invited to join OWL in building the road that will lead to a brighter future for older women.

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